STANDARDS FOR PUBLIC HEALTH IN WASHINGTON

A Collaborative Effort by State and Local Health Officals

Washington State Department of Health

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND HEALTHIER WASHINGTON

Revised January 2005

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Background: Standards for Public Health in Washington State

People depend on the governmental public health system to respond to public health threats and prevent costly health problems that cause illness or death. Every resident and visitor, throughout the state, should be assured that the public health system is working to protect their health at all times. *Standards for Public Health in Washington State* provides a common, consistent and accountable approach to assuring that basic health protection is in place.

Standards for Public Health in Washington State was developed in a collaborative process involving more than 100 public health professionals who work at state and local health departments. They shared their scientific knowledge and practical experience to define standards for the governmental public health system.

The importance of standards

Common standards provide a clear and accountable measure of performance for public health agencies—a level of protection citizens can count on. Setting standards for public health will help us identify what we need to do to strengthen public health protection and will also let us measure improvements in the effectiveness of the public health system.

State laws require that we set basic standards for public health as a part of the biennial Public Health Improvement Plan, a process designed to strengthen the public health system in order to improve the health of people. (See: RCW 43.70.520 and RCW 43.70.580)

Complementary roles for state and local government

In Washington State, responsibility for public health protection is shared among the Washington State Department of Health, the State Board of Health, and 35 local government public health jurisdictions with local boards of health.

Local and state agencies perform different tasks. They have unique, but complementary roles and they rely on one another to make the public health system work. The standards recognize that state and local responsibilities are different. A single standard is proposed for the public health *system*, with separate state and local measures that demonstrate whether a standard is met. All residents depend on this strong partnership between state and local government.

This set of standards was purposely limited to the responsibilities of state and local government. The contributions of non-government health providers and community-based organizations are essential, but they are separate from the specific accountability expected of government agencies.

A common sense framework addressing five key areas

The standards cover five key aspects of public health, selected because they represent basic protection that should be in place everywhere:

- UNDERSTANDING HEALTH ISSUES
- PROTECTING PEOPLE FROM DISEASE
- ASSURING A SAFE AND HEALTHY ENVIRONMENT FOR PEOPLE
- PROMOTING HEALTHY LIVING
- HELPING PEOPLE GET THE SERVICES THEY NEED

In developing the standards, the guiding principles were: define what is *basic*, use clear language, describe what *every* jurisdiction should be able to do regardless of size or location, incorporate the ideas of nationally described core functions and essential services of public health, and support the standards with a few carefully selected measures that demonstrate whether the standards have been met.

The standards focus on the capacity of our public health agencies to perform certain functions and not on specific health issues. A public health system that is well organized, meeting a common set of basic standards and adopting best practices, is better prepared to help bring about improvements in health. In a separate effort, we are developing health and outcome indicators that will answer the questions about: How healthy we are? Who is most affected? Indicators are treated separately from standards because of the belief that it is important to focus on both health trends *and* the level of performance in the public health system.

The standards are not intended to substitute for the complex body of public health law, multiple regulations, and individual county ordinances that have developed over time. The laws and regulations are vitally important to public health protection, but each is intended to address very specific issues. *Standards for Public Health in Washington State* provides a framework to assess how well our governmental public health system is working overall; existing laws and regulations fit very well within that framework.

Meeting the Standards will take time

The standards were field-tested in summer 2000 and used in a baseline measurement of the entire system in 2002. Using information from the baseline, the wording of the measures was revised in 2004 to make them more clear and measurable.

From the baseline test, it was learned that some standards are met now, and some will take time or resources to achieve. It is expected that some standards will be beyond reach for some time to come. Yet, even these unmet standards will provide an important guidepost for our future and a way to measure progress as we work toward meeting them.

The standards are expected to become part of the contract between the state and local agencies in the future, but we expect they will be phased in over time. The Public Health Improvement Plan Act of 1995 required that the state develop "performance-based contracts" with each Local Health Jurisdiction, based on "the core functions of public health." Our approach has been to develop the standards collaboratively with both state and local officials and work to improve the system based on results from the assessments.

Public health is everyone's concern

People care about issues that affect their health. On any given day, a glance at newspaper articles reminds us that people place high value on public health protection. Setting standards for performance of our public health system will assure that basic protection is available to all people in Washington State.

On the following pages...

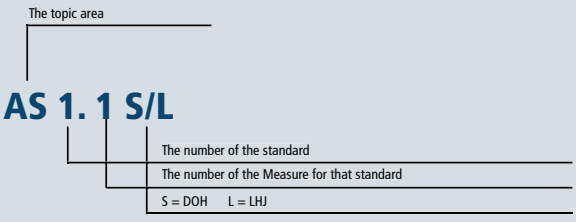
Standard	applies to the whole governmental public health system
Local Measures	lists measures to show that a local health jurisdiction meets the standard
State Measures	lists measures to show that the State Department of Health meets the Standard

While many different measures could be used, these were selected as the best and most practical measures to indicate how well the public health system is meeting each standard.

DOH	Washington State Department of Health
LHJ	Local Health Jurisdiction
BOH	Local Board of Health

Topic Code		Related Section of Standards for Public Health
AS	Assessment	*Understanding Health Issues*
CD	Communicable Disease	*Protecting People from Disease*
EH	Environmental Health	*Assuring a Safe, Healthy Environment for People*
PP	Prevention and Promotion	*Prevention is Best: Promoting Healthy Living*
AC	Access	*Helping People Get the Services They Need*

The Numbering System:



Understanding Health Issues (AS)

Standards for Public Health Assessment

Understanding health issues

PROTECTING PEOPLE FROM DISEASE

ASSURING A SAFE, HEALTHY ENVIRONMENT FOR PEOPLE

PREVENTION IS BEST: PROMOTING HEALTHY LIVING

HELPING PEOPLE GET THE SERVICES THEY NEED

Standard AS1

Public health assessment skills and tools are in place in all public health jurisdictions and their level is continuously maintained and enhanced.

Local measures:

AS1.1L Current information on health issues affecting the community is readily accessible, including qualitative and standardized quantitative data.

AS1.2L There is a written procedure describing how and where to obtain technical assistance on assessment issues.

AS1.3L Goals and objectives are established for assessment activities as a part of LHJ planning, and staff or outside assistance is identified to perform the work.

AS1.4L Information on health issues affecting the community is updated regularly and includes information on communicable disease, environmental health, and community health status. Data being tracked have standard definitions, and standardized measures are used.

AS1.5L Staff who perform assessment activities have documented training and experience in epidemiology, research, and data analysis. Attendance at trainings and peer exchange opportunities to expand available assessment expertise is documented.

State measures:

AS1.1S Consultation and technical assistance are provided to LHJs and state programs on health data collection and analysis, as documented by logs or reports. Coordination is provided in the development and use of data standards including definitions and descriptions.

AS1.2S Written procedures are maintained and disseminated for how to obtain consultation and technical assistance for LHJs or state programs regarding health data collection and analysis and program evaluation.

AS1.3S Goals and objectives are established for assessment activities as a part of DOH planning, and resources are identified to perform the work.

AS1.4S Information on health issues affecting the state is updated regularly and includes information on communicable disease, environmental health, and data about health status. Data being tracked have standard definitions, and standardized qualitative or quantitative measures are used.

AS1.5S Staff members who perform assessment activities have documented training and experience in epidemiology, research, and data analysis. Statewide training and peer exchange opportunities are coordinated and documented.

Standard AS2

Information about environmental threats and community health status is collected, analyzed, and disseminated at intervals appropriate for the community.

Local measures:

AS2.1L Assessment data is provided to community groups and representatives of the broader community for review and identification of emerging issues that may require investigation.

AS2.2L The BOH receives a report annually on a local core set of indicators that includes data about community health status, communicable disease, and environmental health.

AS2.3L There is a planned, systematic process that describes how documented or emerging health issues are identified, assessment data gathered and analyzed, and recommendations are made regarding policy development and action.

AS2.4L Assessment investigations of changing or emerging health issues are part of the LHJ's annual goals and objectives.

AS2.5L A local core set of indicators that includes data about community health status, communicable disease, and environmental health is used as the basis for continuous monitoring of the health status of the community. This set of core indicators tracks data over time to signal changes in priority health issues.

State measures:

AS2.1S Reports are provided to LHJs and other groups. The reports provide health information analysis and include key health indicators tracked over time.

AS2.2S A core set of indicators that include information on communicable disease, environmental health, and data about health status is regularly published and used as the basis for continuous monitoring of the health status of the state. These core indicators track data over time to signal changes in priority health issues.

AS2.3S There is a planned, systematic process involving LHJs as appropriate, that describes how documented or emerging health issues are identified, assessment data gathered and analyzed, and conclusions drawn regarding actions required.

AS2.4S Investigations of changing or emerging health issues are part of the annual goals and objectives established by DOH.

Standard AS3

Public health program results are evaluated to document effectiveness.

Local measures:

AS3.1L Progress towards program goals is reported annually to the BOH via a single, compiled report or a planned calendar of reports.

AS3.2L There is a planned, systematic process that describes how appropriate data is used to evaluate program effectiveness. Programs, whether provided directly or contracted, have written goals, objectives, and performance measures and are based on relevant research.

AS3.3L Program performance measures are monitored, the data is analyzed, and regular reports document the progress towards goals.

AS3.4L LHJ program staff have training in methods to evaluate performance against goals and assess program effectiveness.

AS3.5L There is documentation that performance monitoring data is analyzed and used to change and improve program offerings.

State measures:

AS3.1S Consultation and technical assistance are provided to LHJs and state programs on program evaluation, as documented by case write-ups or logs.

AS3.2S There are planned, systematic processes that describe how appropriate data are used to evaluate DOH program effectiveness. Programs, whether provided directly or contracted, have written goals, objectives, and performance measures and are based on relevant research.

AS3.3S Program performance measures are monitored, the data is analyzed, and regular reports document the progress towards goals.

AS3.4S State and LHJ staff members have been trained on program evaluation as evidenced by documentation of staff training.

AS3.5S There is documentation that programs analyze and use performance monitoring data to change and improve program offerings.

Standard AS4

Health policy decisions are guided by health assessment information with involvement of representative community members.

Local measures:

AS4.1L There is documentation of community involvement in the process of reviewing health data and recommending action such as further investigation, new program effort, or policy direction.

AS4.2L The annual report to the BOH summarizes assessment data, including environmental health, and recommends actions for health policy decisions.

AS4.3L There is a planned, systematic process that describes how health assessment data is used to guide health policy decisions.

AS4.4L Key indicator data being tracked and related recommendations are used in evaluating goals and objectives.

State measures:

AS4.1S There is documentation of stakeholder involvement in DOH health assessment and policy development.

AS4.2S There is a planned, systematic process for using health assessment information to guide health policy decisions.

AS4.3S State health assessment data is linked to health policy decisions as evidenced through legislative requests, budget decisions, programs or grants.

Standard AS5

Health data is handled so that confidentiality is protected and health information systems are secure.

Local measures:

AS5.1L Written policies, including data sharing agreements, govern the use, sharing, and transfer of data within the LHJ and with partner agencies.

AS5.2L All program data are submitted to local, state, regional, and federal agencies in a confidential and secure manner.

State measures:

AS5.1S Written policies, including data sharing agreements, govern the use, sharing, and transfer of data within the DOH and among the DOH, LHJs, and partner agencies.

AS5.2S All program data are submitted to local, state, regional, and federal agencies in a confidential and secure manner.

Protecting People from Disease (CD)

Standards for Communicable Diseases and Other Health Risks

Standard CD1

A surveillance and reporting system is maintained to identify emerging health threats.

Local measures:

CD1.1L Information is provided to the public on how to contact the LHJ to report a public health concern 24 hours per day. Law enforcement has current local and state 24-hour emergency contact lists.

CD1.2L Health care providers and labs know which diseases require reporting, have timeframes, and have 24-hour local contact information. There is a process for identifying new providers in the community and engaging them in the reporting process.

CD1.3L There are annual reports to the BOH that include communicable disease surveillance activity and related data from the local core set of indicators.

CD1.4L Written protocols are maintained for receiving and managing information on notifiable conditions. The protocols include role-specific steps to take when receiving information as well as guidance on providing information to the public.

CD1.5L The local core indicators relating to communicable disease are analyzed annually, and implications for changes in investigation, intervention, or education efforts are identified.

CD1.6L A communicable disease tracking system is used which documents the initial report, investigation, findings, and subsequent reporting to state and federal agencies.

CD1.7L There is documentation that staff members receive training on reporting of communicable disease.

State measures:

CD1.1S Information is provided to the public on how to contact the DOH to report a public health concern 24 hours per day. Law enforcement has current, state 24-hour emergency contact lists.

CD1.2S Consultation and technical assistance are provided to LHJs on surveillance and reporting as documented by case summaries or reports. Laboratories and health care providers, including new licensees, are provided with information on disease reporting requirements, timeframes, and a 24-hour DOH point of contact.

CD1.3S Written procedures are maintained and disseminated for how to obtain state or federal consultation and technical assistance for LHJs. Assistance includes surveillance, reporting, disease intervention management during outbreaks or public health emergencies, and accuracy and clarity of public health messages.

CD1.4S Annual goals and objectives for communicable disease are a part of the DOH planning process. Key indicators and implications for investigation, intervention, or education efforts are documented.

CD1.5S A statewide database for reportable conditions is maintained; surveillance data are summarized and disseminated to LHJs at least annually. Uniform data standards and case definitions are updated and published at least annually.

CD1.6S Staff members receive training on reporting of communicable disease as evidenced by training documentation.

Standard CD2

Response plans delineate roles and responsibilities in the event of communicable disease outbreaks and other health risks that threaten the health of people.

Local measures:

CD2.1L Phone numbers for weekday and after-hours emergency contacts are available to DOH and appropriate local agencies, such as schools and hospitals.

CD2.2L A primary contact person or designated phone line for the LHJ is clearly identified in communications to health providers and appropriate public safety officials for reporting purposes.

CD2.3L Written policies or procedures delineate specific roles and responsibilities within agency divisions for local response and case investigations of disease outbreaks and other health risks.

State measures:

CD2.1S Phone numbers for after-hours contacts for all local and state public health jurisdictions are updated and disseminated statewide at least annually.

CD2.2S Written policies or procedures delineate specific roles and responsibilities for state response to disease outbreaks or public health emergencies. There is a formal description of the roles and relationship between communicable disease, environmental health, and program administration. Variations from overall process are identified in disease-specific protocols.

CD2.3S Written procedures describe how expanded lab capacity is made readily available when needed for outbreak response, and there is a current list of labs having the capacity to analyze specimens.

CD2.4S DOH staff members receive training on the policies and procedures regarding roles and responsibilities for response to public health threats as evidenced by protocols.

Standard CD3

Communicable disease investigation and control procedures are in place and actions documented.

Local measures:

CD3.1L Lists of private and public sources for referral to treatment are accessible to LHJ staff.

CD3.2L Information is given to local providers through public health alerts and newsletters about managing reportable conditions.

CD3.3L Disease-specific protocols identify information about the disease, case investigation steps (including timeframes for initiating the investigation), reporting requirements, contact and clinical management (including referral to care), use of emergency biologics, and the process for exercising legal authority for disease control (including non-voluntary isolation). Documentation demonstrates staff member actions are in compliance with protocols and state statutes.

CD3.4L An annual self-audit, using a sample of communicable disease investigations, is done to monitor timeliness and compliance with disease-specific protocols.

CD3.5L LHJs identify key performance measures for communicable disease investigation and enforcement actions.

CD3.6L Staff members conducting disease investigations have appropriate skills and training as evidenced in job descriptions and resumes.

State measures:

CD3.1S Consultation and staff time are provided to LHJs for local support of disease intervention management during outbreaks or public health emergencies as documented by case write-ups. Recent research findings relating to the most effective population-based methods of disease prevention and control are provided to LHJs. Labs are provided written protocols for the handling, storage, and transportation of specimens.

CD3.2S DOH leads statewide development and use of a standardized set of written protocols and state statutes for communicable disease investigation and control, including templates for documentation. Disease-specific protocols identify information about the disease, case investigation steps (including timeframes for initiating investigations), reporting requirements, contact and clinical management (including referral to care), use of emergency biologics, and the process for exercising legal authority for disease control (including non-voluntary isolation).

CD3.3S An annual self-audit of a sample of DOH communicable disease investigations is done to monitor timeliness and compliance with disease-specific protocols.

CD3.4S DOH identifies key performance measures for communicable disease investigations and consultation.

CD3.5S Staff members conducting disease investigations have appropriate skills and training as evidenced in job descriptions and resumes.

Standard CD4

Urgent public health messages are communicated quickly and clearly and actions documented.

Local measures:

CD4.1L Information is provided through public health alerts to key stakeholders and press releases to the media.

CD4.2L A current contact list of media and providers is maintained and updated at least annually. This list is in the communicable disease manual and at other appropriate departmental locations.

CD4.3L Roles are identified for working with the news media. Policies identify the timeframes for communications and the expectations for all staff regarding information sharing and response to questions as well as the steps for creating and distributing clear and accurate public health alerts and media releases.

CD4.4L All staff that have lead roles in communicating urgent messages have been trained in risk communications.

State measures:

CD4.1S A communication system is maintained for rapid dissemination of urgent public health messages to the media and other state and national contacts.

CD4.2S A communication system is maintained for rapid dissemination of urgent public health messages to LHJs, other agencies, and health providers. Consultation is provided to LHJs to assure the accuracy and clarity of public health information associated with an outbreak or public health emergency as documented by case write-ups. State-issued announcements are shared with LHJs in a timely manner.

CD4.3S Roles are identified for working with the news media. Written policies identify the timeframes for communications and the expectations for all staff regarding information sharing and response to questions as well as the steps for creating and distributing clear and accurate public health alerts and media releases.

CD4.4S Communication issues identified in outbreak response evaluations are addressed in writing with future goals and objectives in the communicable disease quality improvement plan.

CD4.5S All staff that have lead roles in communicating urgent messages have been trained in risk communications.

Standard CD5

Communicable disease and other health risk responses are routinely evaluated for opportunities to improve public health system response.

Local measures:

CD51.L An evaluation for each significant outbreak response documents what worked well and what process improvements are recommended for the future. Feedback is solicited from appropriate entities, such as hospitals and providers. Meetings are convened to assess how the outbreak was handled, identify issues, and recommend changes in response procedures.

CD5.2L Recommendations based on outbreak response evaluation and recommendations for effective response efforts are reported to the BOH.

CD5.3L Local protocols are revised based on outbreak response evaluation findings or model materials disseminated by DOH.

CD5.4L Issues identified in outbreak evaluations are addressed in future goals and objectives for communicable disease programs.

CD5.5L Staff training in communicable disease and other health risk issues is documented.

CD5.6L There is documentation that outbreak responses are evaluated and that evaluation findings are used for process improvement, which takes into consideration surveillance processes, staff roles, investigation procedures, and communication efforts.

State measures:

CD5.1S Timely information about best practices in disease control is gathered and disseminated. Coordination is provided for a state and local debriefing to evaluate extraordinary disease events that required a multi-agency response; a written summary of evaluation findings and recommendations is disseminated statewide.

CD5.2S Model plans, protocols, and evaluation templates for response to disease outbreaks or public health emergencies are developed and disseminated to LHJs.

CD5.3S Model materials are revised based on evaluation findings, including review of outbreaks.

CD5.4S Response issues identified in outbreak evaluations are addressed in future goals and objectives for communicable disease programs.

CD5.5S Staff members are trained in surveillance, outbreak response, and communicable disease control and are provided with standardized tools.

CD5.6S There is documentation that outbreak responses are evaluated and that evaluation findings are used for process improvement, which takes into consideration surveillance processes, staff roles, investigation procedures, and communication efforts.

Assuring a Safe, Healthy Environment for People (EH)

Standards for Environmental Health

Standard EH1

Environmental health education is a planned component of public health programs.

Local measures:

EH1.1L Information is available about environmental health, including compliance requirements, through brochures, flyers, newsletters, websites, or other mechanisms.

EH1.2L The community and stakeholders are involved in appropriate ways in addressing environmental health issues, including through presentations or individual technical assistance.

EH1.3L Environmental health education information in all forms (including technical assistance) is reviewed at least annually and updated, expanded, or contracted as needed based on revised regulations, changes in community needs, etc.

EH1.4L The critical components of all EH activities are identified and used as the basis for education that is provided. Workshops and other in-person trainings (including technical assistance) are evaluated to determine effectiveness.

State measures:

EH1.1S Information is provided to the public about the availability of state level environmental health through brochures, flyers, newsletters, websites, or other mechanisms.

EH1.2S Stakeholders are involved in appropriate ways in addressing environmental health issues, including through presentations or technical assistance.

EH1.3S Environmental health education information in all forms (including technical assistance) is reviewed at least annually and updated, expanded, or contracted as needed based on revised regulations, changes in stakeholder needs, etc.

EH1.4S Environmental health education is provided in conformance with needs of stakeholders, as identified through meetings, surveys, or other assessment means.

EH1.5S Environmental health education is assessed for effectiveness through evaluations of participants, surveys, or other means.

EH1.6S Staff members conducting environmental health education have skills (health education, communication, etc) as evidenced by job descriptions, resumes, or training documentation.

Standard EH2

Services are available throughout the state to respond to environmental events or natural disasters that threaten the public's health.

Local measures:

EH2.1L Information is provided to the public on how to contact local jurisdictions to report environmental health threats or public health emergencies 24 hours a day.

EH2.2L Environmental health threats and public health emergencies are included in the local emergency response plan. After a public health emergency response involving environmental health occurs, environmental health staff are included in the local jurisdiction after-action debrief. Any changes to the response plan affecting environmental health response are documented.

EH2.3L Environmental health services that are critical to access in different types of emergencies are identified. Public education and outreach includes information on how to access these critical services. After-action debrief includes a review of the accessibility of those services, and any changes necessary are made and documented.

EH2.4L There is a plan that details the roles and responsibilities for LHJ staff in a natural disaster or other public health emergency that both stands alone and is part of the local emergency response plan. All LHJ staff receive annual training on their respective duties.

State measures:

EH2.1S Information is provided to the public on how to report environmental health threats or public health emergencies 24 hours a day; this includes a phone number.

EH2.2S Environmental health threats and public health emergencies are included in the emergency response plan. After a public health emergency response involving environmental health occurs, environmental health staff are included in the after-action debrief. Any changes to the response plan affecting environmental health response are documented.

EH2.3S Written procedures are maintained and disseminated for how to obtain consultation and technical assistance regarding emergency preparedness for environmental events or natural disasters that threatens the public's health. Procedures are in place to evaluate the effectiveness of these emergency response plans. Plans or procedures are revised based on event debriefing findings and recommendations.

EH2.4S There is a plan that describes DOH internal roles and responsibilities for environmental events or natural disasters that threaten the health of the people. There is a clear link between this plan and other state and local emergency response plans.

EH2.5S Appropriate DOH program staff are trained in risk communication and the DOH emergency response plan as evidenced by training documentation.

Standard EH3

Both environmental health risks and environmental health illnesses are tracked, recorded, and reported.

Local measures:

EH3.1L Environmental health data is available for community groups and other local agencies to review.

EH3.2L Key indicators of environmental health risks and illnesses are identified. A system is in place for reporting suspected environmental health illnesses based on those indicators, and reporting is tracked to monitor trends. A system is in place to assure the data is shared with appropriate local, state, and regional agencies.

EH3.3L Public requests, BOH testimony, compliance rates, and other data and information are used to determine what internal or external quality improvements may be needed. If needed, a plan is developed to institute needed changes over time

State measures:

EH3.1S Coordination to develop environmental health indicators and data standards is provided.

EH3.2S Key indicators of environmental health risks and illnesses are identified. A system is in place for reporting of any suspected environmental health illnesses based on those indicators, and reporting is tracked to monitor trends. A system is in place to assure the data is shared with appropriate local, regional, state, and national agencies.

EH3.3S Public requests, testimony before the State Board of Health, compliance rates, and other data and information is used to determine what internal or external quality improvements may be needed. If needed, a plan is developed to institute changes over time.

Standard EH4

Compliance with public health regulations is sought through enforcement actions.

Local measures:

EH4.1L Written policies, local ordinances, administrative code, and enabling laws are accessible to the public.

EH4.2L There are written procedures to follow for enforcement actions. The procedures specify the type of documentation needed to take an enforcement action, which conforms with local policies, ordinances, and state laws.

EH4.3L A selected number of enforcement actions are evaluated each year to determine compliance with and effectiveness of enforcement procedures. If needed, procedures are revised.

EH4.4L Enforcement actions are logged (tracked) from the initial report, through the investigation, findings, and enforcement action and are reported to other agencies as required.

EH4.5L Appropriate environmental health staff are trained on enforcement procedures.

State measures:

EH4.1S Written policies, local ordinances, laws, and administrative codes are accessible to the public.

EH4.2S Information about best practices in environmental health compliance activity is gathered and disseminated or posted to agency's website, including, as appropriate, form templates, time frames, interagency coordination steps, hearing procedures, citation issuance, and documentation requirements.

EH4.3S There are written procedures to follow for enforcement actions. The procedures specify the type of documentation needed to take an enforcement action, which conforms with state law.

EH4.4S There is a documented process for periodic review of enforcement actions and a selected number of enforcement actions are evaluated each year to determine compliance with and effectiveness of enforcement procedures. If needed, procedures are revised.

EH4.5S Enforcement actions are logged (tracked) from the initial report through the investigation, findings, and enforcement action and are reported to other agencies as required.

EH4.6S Appropriate environmental health staff are trained on enforcement procedures as evidenced by training documentation.

Prevention is Best: Promoting Healthy Living (PP)

Standards for Prevention and Community Health Promotion

Standard PP1

Policies are adopted that support prevention priorities and that reflect consideration of scientifically-based public health literature.

Local measures:

PP1.1L Prevention and health promotion priorities are selected with involvement from community groups and other organizations interested in the public's health.

PP1.2L Prevention and health promotion priorities are adopted by the BOH based on assessment information, local issues, funding availability, program evaluation, and experience in service delivery, including information on best practices or scientific findings.

PP1.3L Prevention and health promotion priorities are reflected in the goals, objectives, and performance measures of the LHJ's annual plan. Data from program evaluation and key indictors is used to develop strategies.

State measures:

PP1.1S Reports about new or emerging issues that contribute to health policy choices are routinely developed and disseminated. Reports include information about best practices in prevention and health promotion programs.

PP1.2S Consultation and technical assistance is available to assist LHJs in proposing and developing prevention and health promotion policies and initiatives. Written procedures are maintained and shared, describing how to obtain consultation and assistance regarding development, delivery, or evaluation of prevention and health promotion initiatives.

PP1.3S Priorities are set for prevention and health promotion services, and plans are developed with goals, objectives, and performance measures.

PP1.4S The statewide plan is evaluated and revised regularly, incorporating information from health assessment data and program evaluation.

Standard PP2

Active involvement of community members is sought in addressing prevention priorities.

Local measures:

PP2.1L The LHJ involves a broad range of community partners in considering assessment information to set prevention priorities.

PP2.2L Staff members have training in community mobilization methods as evidenced by training documentation.

State measures:

PP2.1S DOH involves community members, partners, and stakeholders and uses data to set prevention and health promotion priorities.

PP2.2S DOH collects information about successful community mobilization efforts for prevention and health promotion priorities. These examples are shared with other DOH programs, LHJs, and stakeholders.

PP2.3S The statewide plan for prevention and health promotion identifies efforts to link public and private partnerships into a network of prevention services.

PP2.4S DOH staff members have training in community mobilization methods as evidenced by training documentation.

Standard PP3

Access to high quality prevention services for individuals, families, and communities is encouraged and enhanced by disseminating information about available services and by engaging in and supporting collaborative partnerships.

Prevention services may be focused on reaching individuals, families, and communities. Examples of prevention services include chronic disease prevention, home visiting by public health nurses, immunization programs, efforts to reduce unintentional injuries and violence, including sexual assault.

Local measures:

PP3.1L Summary information is available to the public describing preventive services available in the community. This may be produced by a partner organization or the LHJ, and it may be produced in a paper or web-based format.

PP3.2L Local prevention services are evaluated and a gap analysis that compares existing community prevention services to projected need for services is performed periodically and integrated into the priority setting process.

PP3.3L Results of prevention program evaluation and analysis of service gaps are reported to local stakeholders and to peers in other communities.

PP3.4L A quality improvement plan incorporates program evaluation findings, evaluation of community mobilization efforts, use of emerging literature and best practices, and delivery of prevention and health promotion services.

State measures:

PP3.1S DOH supports best use of available resources for prevention services through leadership, collaboration, and communication with partners. Information about prevention and health promotion evaluation results is collected and shared statewide.

PP3.2S Prevention programs, provided directly or by contract, are evaluated against performance measures and incorporate assessment information. In addition, a gap analysis that compares existing prevention services to projected need for services is performed periodically and integrated into the priority setting process.

PP3.3S A quality improvement plan incorporates program evaluation findings, evaluation of community mobilization efforts, use of emerging literature and best practices, and delivery of prevention and health promotion services.

Standard PP4

Prevention, early intervention, and outreach services are provided directly or through contracts.

Health promotion activities may be focused on the entire state or community or on groups within the community. Examples of health promotion activities include educational efforts aimed at increasing physical activity, reduction in tobacco use, improved dietary choices.

Local measures:

PP4.1L Prevention priorities adopted by the BOH are the basis for establishing and delivering prevention, early intervention, and outreach services.

PP4.2L Early intervention, outreach, and health education materials address the diverse local populations and languages of the intended audience. Information about how to select appropriate materials is available and used by staff.

PP4.3L Prevention programs collect and use information from outreach, screening, referrals, case management, and follow-up for program improvement. Prevention programs, provided directly or by contract, are evaluated against performance measures and incorporate assessment information. The type and number of prevention services are included in program performance measures.

PP4.4L Staff providing prevention, early intervention, or outreach services have appropriate skills and training as evidenced by job descriptions, resumes, or training documentation.

State measures:

PP4.1S Consultation and technical assistance on program implementation and evaluation of prevention services is provided for LHJs. There is a system to inform LHJs and other stakeholders about prevention funding opportunities.

PP4.2S Outreach and other prevention interventions are reviewed for compliance with science, professional standards, and state and federal requirements. Consideration of professional requirements and competencies for effective prevention staff is included.

PP4.3S Prevention services have performance measures that are tracked and analyzed, and recommendations are made for program improvements.

PP4.4S Statewide templates for documentation and data collection are provided for LHJs and other contractors to support performance measurement.

PP4.5S DOH staff members have training in prevention, early intervention, or outreach services as evidenced by training documentation.

Standard PP5

Health promotion activities are provided directly or through contracts.

Local measures:

PP5.1L Health promotion activities intended to reach the entire population or at-risk populations in the community are provided directly by LHJs or by contractors.

PP5.2L Procedures describe an overall system to organize, develop, distribute, evaluate, and update health promotion materials. Technical assistance is provided to community organizations, including "train-the-trainer" methods.

PP5.3L Health promotion efforts have goals, objectives, and performance measures. The number and type of health promotion activities are tracked and reported, including information on content, target audience, number of attendees. There is an evaluation process for health promotion efforts that is used to improve programs or revise curricula.

PP5.4L Staff members have training in health promotion methods as evidenced by training documentation.

State measures:

PP5.1S DOH provides health promotion activities intended to reach either the entire population or at-risk populations in the community.

PP5.2S Literature reviews of health promotion effectiveness are conducted and disseminated. Consultation and technical assistance on health promotion implementation and evaluation is provided for LHJs. There is a system to inform LHJs and other stakeholders about health promotion funding opportunities.

PP5.3S Health promotion activities are reviewed for compliance with science, professional standards, and state and federal requirements. Health promotion materials that are appropriate for statewide use and for key cultural or linguistic groups are made available to LHJs and other stakeholders through a system that organizes, develops, distributes, evaluates, and updates the materials.

PP5.4S Health promotion activities have goals, objectives, and performance measures that are tracked and analyzed, and recommendations are made for program improvements. The number and type of health promotion activities are tracked and reported, including information on content, target audience, number of attendees. There is an evaluation process for health promotion efforts that is used to improve programs or revise curricula.

PP5.5S DOH staff members have training in health promotion methods as evidenced by training documentation.

Helping People Get the Services They Need (AC)

Standards for Access to Critical Health Services

UNDERSTANDING HEALTH ISSUES

PROTECTING PEOPLE FROM DISEASE

ASSURING A SAFE, HEALTHY ENVIRONMENT FOR PEOPLE

PREVENTION IS BEST: PROMOTING HEALTHY LIVING

Helping people get the services they need

Standard AC1

Information is collected and made available at both the state and local level to describe the local health system, including existing resources for public health protection, health care providers, facilities, and support services.

Local measures:

AC1.1L Up-to-date information for analysis of local critical health services is available for use in building partnerships with community groups and stakeholders.

AC1.2L LHJ staff and contractors have a resource list of local providers of critical health services for use in making client referrals.

AC1.3L The list of critical health services* is used along with assessment information to determine where detailed documentation of local capacity is needed.

State measures:

AC1.1S A list of critical health services and a core set of statewide access measures are established. Information is collected on the core set of access measures, analyzed, and reported to the LHJs and other agencies.

AC1.2S Information is provided to LHJs and other agencies about availability of licensed health care providers, facilities, and support services.

Standard AC2

Available information is used to analyze trends that, over time, affect access to critical health services.*

Local measures:

AC2.1L Data tracking and reporting systems include key measures of access. Periodic surveys are conducted regarding the availability of critical health services and barriers to access.

AC2.2L Gaps in access to critical health services* are identified through analysis of the results of periodic surveys and other assessment information.

AC2.3L The BOH receives summary information regarding access to critical health services at least annually.

State measures:

AC2.1S Consultation is provided to communities to help gather and analyze information about barriers to accessing critical health services.*

AC2.2S Written procedures are maintained and disseminated for how to obtain consultation and technical assistance for LHJs and other agencies in gathering and analyzing information regarding barriers to access.

AC2.3S Gaps in access to critical health services are identified through analysis of the results of periodic surveys and other data tracking.

AC2.4S Periodic studies regarding workforce needs and the effect on critical health services* are analyzed and disseminated to LHJs and other agencies.

Standard AC3

Plans to reduce specific gaps in access to critical health services are developed and implemented through collaborative efforts.

Local measures:

AC3.1L Community groups and stakeholders, including health care providers, are convened to address access to critical health services,* set goals, and take action based on information about local resources and trends. This process may be led by the LHJ or it may be part of a separate community process sponsored by multiple partners including the LHJ.

AC3.2L Coordination of critical health service delivery among health providers is reflected in the local planning processes and in the implementation of access initiatives.

AC3.3L Where specific initiatives are selected to improve access, there is analysis of local data and established goals, objectives, and performance measures.

State measures:

AC3.1S Information about access barriers affecting groups within the state is shared with other state agencies that pay for or support critical health services.*

AC3.2S State-initiated contracts and program evaluations include performance measures that demonstrate coordination of critical health services* delivery among health providers.

AC3.3S Protocols are developed for implementation by state agencies, LHJs, and other local providers to maximize enrollment and participation in available insurance coverage.

AC3.4S Where specific initiatives are selected to improve access, there is analysis of local data and established goals, objectives, and performance measures.

Standard AC4

Quality measures that address the capacity, process for delivery, and outcomes of critical health care services are established, monitored, and reported.

Local measures:

AC4.1L Clinical services provided directly by the LHJ or by contract have a written quality improvement plan including specific quality-based performance or outcome measures. Performance measures are tracked and reported.

AC4.2L Staff members are trained in quality improvement methods as evidenced by training documentation.

State measures:

AC4.1S Information about best practices in delivery of critical health services* is gathered and disseminated. Summary information regarding delivery system changes is provided to LHJs and other agencies.

AC4.2S Training on quality improvement methods is available and is incorporated into grant and program requirements.

AC4.3S Regulatory programs and clinical services administered by DOH have a written quality improvement plan including specific, quality-based performance or outcome measures.

Menu of Critical Health Services*

This menu identifies health services and health conditions or risks for which appropriate services — screening, education and counseling, or interventions — are needed.

General access to health services

- Ongoing primary care
- Emergency medical services and care
- Consultative specialty care
- Home care services
- Long-term care

Health risk behaviors

- Tobacco use
- Dietary behaviors
- Physical activity and fitness
- Injury and violence prevention (bike safety, motor vehicle safety, firearm safety, poison prevention, abuse prevention)
- Responsible sexual behavior

Communicable and infectious diseases

- Immunizations for vaccine-preventable diseases
- HIV/AIDS
- Tuberculosis
- Other communicable diseases

Pregnancy and maternal, infant, and child health and development

- Family planning
- Prenatal care
- Women, Infants and Children (WIC) services
- Well child care

Behavioral health and mental health services

- Substance abuse prevention and treatment
- Depression
- Suicide/crisis intervention
- Other serious mental illness

Cancer services

- Cancer-specific screening (i.e., breast, cervical, colorectal) and surveillance
- Specific cancer treatment

Chronic conditions and disease management

- Diabetes
- Asthma
- Hypertension
- Cardiovascular disease
- Respiratory diseases (other than asthma)
- Arthritis, osteoporosis, chronic back conditions
- Renal disease

Oral health

- Dental care services
- Water fluoridation

Crosswalk of Three Core Functions and Ten Essential Services to Standards

For the past decade, Washington State has used the federally develped "Core Functions" and the "Ten Essential Services of Public Health" as a foundation for our work on public health improvement. These concepts are incorporated into our Standards for Public Health. The Standards and measures are organized into six topic areas:

- Understanding Health Issues
- Protecting People From Disease
- Assuring a Safe, Health Environment
- Prevention is Best: Promoting Healthy Living
- Helping People Get the Services They Need

The Core Functions of Public Health

Public health officials cannot protect the health of their communities effectively if they focus only on individual programs, diseases or threats. They must be prepared for new health problems that emerge. The core function approach helps health departments and their communities prepare for new health threats and other emerging issues. Washington State has used this approach in planning for public health system improvements by making the system more responsive to changing needs. The following is a summary of how the Core Functions work.

Assessment

Helps us determine how, where and when health treats are occurring. It includes collection, analysis and dissemination of information on health status, incidence of health problems and risks, choices about health behavior, environmental health concerns, availability and quality of services, and the concerns, availability and quality of services, and the concerns of individuals.

Policy Development

Used to set a course for specific action or regulation to improve or protect health. It may involve a formal public process, as with a local Board of Health. Private organizations and citizen groups also develop policy.

Assurance

Means making sure the right things happen – that we have the health information we need, that we adhere to the policies we have chosen, and that needed services are available. Government programs often play an assurance or oversight role, but they do not provide all the needed services. The public health system depends on the combined efforts of many private, community-based, and public agencies.

The 10 Essential Services are:

Assessment

- Monitor health status of the community.
- Diagnose and investigate health problems and hazards.
- Inform and educate people about health issues.

Policy Development

- Mobilize partnerships to solve community problems.
- Support policies and plans to achieve health goals.

Assurance

- Enforce laws and regulations to achieve health goals.
- Link people to needed personal health services.
- Ensure a skilled public health workforce.
- Evaluate effectiveness, accessibility, and quality of health services.
- Research and apply innovative solutions.

The following matrix compares the three Core Functions and federal framework of 10 Essential Services of Public Health with the Standards for Public Health in Washington State. Local and state health officials drafted the Standards with frequent reference to the 10 Essential Services, but they did not use the federal framework to organize their work. Instead, they chose to develop Standards in five topic areas. For each area, they sought to assure that the 10 Essential Services were addressed. Please note that the Standards, as referenced here, are abbreviated. An entire Standard and its measures must be read to understand its scope.

Core Functions and 10 Essential Services

Topic Area Standard	Assessment			Policy dev't		Assurance				
	Monitor	Investigate	Inform	Mobile	Policies	Enforce	Services	Workforce	Evaluate	Research
Assessment										
1. Assessment skills and tools in place	X	X						X		
2. Information collected, analyzed, and disseminated	X	X	X		X			X	X	
3. Effectiveness of programs is evaluated	X							X	X	X
4. Health policy reflects assessment information		X	X	X						
5. Confidentiality and security of data protected								X		
Communicable disease										
1. Surveillance and reporting system maintained	X	X	X			X		X		X
2. Response plans delineate roles			X	X				X		
3. Documented investigation and control procedures		X			X	X	X	X	X	
4. Urgent messages communicated quickly			X	X			X	X		
5. Response plans routinely evaluated			X					X	X	X
Environmental health										
1. Environmental health education planned		X	X	X				X		
2. Response prepared for environmental threats	X	X		X			X	X	X	
3. Risks and events tracked and reported	X		X	X					X	X
4. Enforcement actions taken for compliance						X		X		
Prevention/health promotion										
1. Policies support prevention priorities	X	X	X		X			X		X
2. Community involvement in setting priorities			X	X	X					
3. Access to prevention services			X	X			X	X	X	X
4. Prevention, early intervention provided				X	X		X	X		
5. Health promotion activities provided			X	X	X			X	X	X
Access to critical services										
1. Information on service availability	X		X				X			
2. Information shared on trends, over time		X	X						X	X
3. Plans developed to reduce specific gaps			X	X	X		X		X	
4. Quality and capacity monitored and reported			X			X		X	X	X

PHIP Laws

RCW 43.70.520

Public health services improvement plan.

(1) The legislature finds that the public health functions of community assessment, policy development, and assurance of service delivery are essential elements in achieving the objectives of health reform in Washington state. The legislature further finds that the populationbased services provided by state and local health departments are cost-effective and are a critical strategy for the long-term containment of health care costs. The legislature further finds that the public health system in the state lacks the capacity to fulfill these functions consistent with the needs of a reformed health care system.

(2) The department of health shall develop, in consultation with local health departments and districts, the state board of health, the health services commission, area Indian health service, and other state agencies, health services providers, and citizens concerned about public health, a public health services improvement plan. The plan shall provide a detailed accounting of deficits in the core functions of assessment, policy development, assurance of the current public health system, how additional public health funding would be used, and describe the benefits expected from expanded expenditures.

(3) The plan shall include:

(a) Definition of minimum standards for public health protection through assessment, policy development, and assurances:

(i) Enumeration of communities not meeting those standards;

(ii) A budget and staffing plan for bringing all communities up to minimum standards;

(iii) An analysis of the costs and benefits expected from adopting minimum public health standards for assessment, policy development, and assurances;

(b) Recommended strategies and a schedule for improving public health programs throughout the state, including:

(i) Strategies for transferring personal health care services from the public health system, into the uniform benefits package where feasible; and

(ii) Timing of increased funding for public health services linked to specific objectives for improving public health; and

(c) A recommended level of dedicated funding for public health services to be expressed in terms of a percentage of total health service expenditures in the state or a set per person amount; such recommendation shall also include methods to ensure that such funding does not supplant existing federal, state, and local funds received by local health departments, and methods of distributing funds among local health departments.

(4) The department shall coordinate this planning process with the study activities required in section 258, chapter 492, Laws of 1993.

(5) By March 1, 1994, the department shall provide initial recommendations of the public health services improvement plan to the legislature regarding minimum public health standards, and public health programs needed to address urgent needs, such as those cited in subsection (8) of this section.

(6) By December 1, 1994, the department shall present the public health services improvement plan to the legislature, with specific recommendations for each element of the plan to be implemented over the period from 1995 through 1997.

(7) Thereafter, the department shall update the public health services improvement plan for presentation to the legislature prior to the beginning of a new biennium.

(8) Among the specific population-based public health activities to be considered in the public health services improvement plan are: Health data assessment and chronic and infectious disease surveillance; rapid response to outbreaks of communicable disease; efforts to prevent and control specific communicable diseases, such as tuberculosis and acquired immune deficiency syndrome; health education to promote healthy behaviors and to reduce the prevalence of chronic disease, such as those linked to the use of tobacco; access to primary care in coordination with existing community and migrant health clinics and other not for profit health care organizations; programs to ensure children are born as healthy as possible and they receive immunizations and adequate nutrition; efforts to prevent intentional and unintentional injury; programs to ensure the safety of drinking water and food supplies; poison control; trauma services; and other activities that have the potential to improve the health of the population or special populations and reduce the need for or cost of health services.

[1993 c 492£ 467.]

RCW 43.70.580

Public health improvement plan—Funds—Performance-based contracts—Rules—Evaluation and report.

The primary responsibility of the public health system, is to take those actions necessary to protect, promote, and improve the health of the population. In order to accomplish this, the department shall:

(1) Identify, as part of the public health improvement plan, the key health outcomes sought for the population and the capacity needed by the public health system to fulfill its responsibilities in improving health outcomes.

(2)(a) Distribute state funds that, in conjunction with local revenues, are intended to improve the capacity of the public health system. The distribution methodology shall encourage system-wide effectiveness and efficiency and provide local health jurisdictions with the flexibility both to determine governance structures and address their unique needs.

(b) Enter into with each local health jurisdiction performance-based contracts that establish clear measures of the degree to which the local health jurisdiction is attaining the capacity necessary to improve health outcomes. The contracts negotiated between the local health jurisdictions and the department of health must identify the specific measurable progress that local health jurisdictions will make toward achieving health outcomes. A community assessment conducted by the local health jurisdiction according to the public health improvement plan, which shall include the results of the comprehensive plan prepared according to RCW 70.190.130, will be used as the basis for identifying the health outcomes. The contracts shall include provisions to encourage collaboration among local health jurisdictions. State funds shall be used solely to expand and complement, but not to supplant city and county government support for public health programs.

(3) Develop criteria to assess the degree to which capacity is being achieved and ensure compliance by public health jurisdictions.

(4) Adopt rules necessary to carry out the purposes of chapter 43, Laws of 1995.

(5) Biennially, within the public health improvement plan, evaluate the effectiveness of the public health system, assess the degree to which the public health system is attaining the capacity to improve the status of the public's health, and report progress made by each local health jurisdiction toward improving health outcomes.

[1995 c 43£ 3.]

DOH Pub 820-022 1/2005